State of Connecticut
GENERAL ASSEMBLY

COMMISSION ON CHILDREN

Testimony of
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Senator Gaffey, Representative Fleischmann and Members of the Committee,

My name is Elaine Zimmerman. I am the Executive Director of the CT Commission on Children. I am here today to speak on a few bills concerning early school success, school health and safety and parent engagement. In particular, I will speak on SB 376, An Act Concerning Full Day Kindergarten, SB 407, An Act Concerning Reading Programs in Priority School Districts, HB 5517 An Act Concerning Universal Preschool, HB 5513, and An Act Concerning Parental Involvement Reporting in School Profiles, and the child nutrition bills, (RB 381, 375), and HB 5563 and 5548 regarding bullying.

Early Reading Success -SB 407 improves our reading interventions for students. Specifically, the interventions for children with reading difficulty begin in grades one, two and three rather than four and six. Evaluations for a child with reading difficulty are not limited to mid-year evaluations and reading plans are to be implemented to ensure that the student receives prompt intervention. Parents are to be notified and engaged in the reading interventions. Summer school is required for a student who is not at grade level in literacy.

These steps are important. Children should be reading in grades one, two and three. If we wait until fourth grade, we will have missed the train. If we intervene just once a year after one evaluation the student's learning needs will have not been adequately addressed. But this is not enough.

Downturn in Reading Scores. CT is tempered by an overall downturn in reading scores for the state's fourth-graders on both the national test and the state's Mastery Test in 2005. In 2005, Connecticut ranked worst in the nation in "poverty gap in proficiency" on the NAEP tests. The state's fourth-graders once topped the nation in reading scores, but last year fell behind children in Massachusetts.

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The achievement gap reflected 71% of Hispanic/Latino taking children the CMT did not have proficiency reading and 65% of African-American taking the CMT did not have proficiency reading. Education Week noted some additional discouraging findings for Connecticut, including a decline in performance in eighth-grade reading scores between 1998 and 2005 and a slight widening of the achievement gap in both reading and math between white and black eighth-graders.

Research has shown that 95% of all children can learn to read, but fewer than half of our students are reading at grade level in many Connecticut towns. In a special forum to address the latest reading scores and their implications, led by the Higher Education Committee Co-Chairs, literacy experts, legislators and SDE the following consensus reached was:

- Teaching children to read is complex and requires a sophisticated body of knowledge, much of which is not given to teachers either at the pre-service or in-service level.

- Teachers are not the ones at fault for this lack of knowledge. Schools of education and state departments of education and higher education should require better teacher preparation.

Teachers show modest training in reading. These findings are further justified by two researchers who shared findings regarding Connecticut's teachers. Jule McCombes-Tolis at Southern Connecticut State University and Richard Feinn at Yale University compared teacher's literacy-related knowledge to the state standards for reading and found that fewer than 50% of the teachers surveyed were able to identify core reading competencies for children learning to read. These included when children should know sounds for common vowel patterns, when children are expected to read with expression, when children should represent sounds in a word while spelling independently and when children should recognize that print is read left to right and top to bottom. Less than half the teachers knew when children should have skills in comprehension and reading accuracy.

Teachers coming out of college are unprepared to teach reading to those who are having difficulty learning to read. They need more coursework on structure of language and wording, as well as developmental processes in reading, which is research based. Currently only 2-3 courses in reading are required to obtain a teaching degree. *Most* degree candidates are not taught how to teach reading, how to assess a child who is having difficulty or how to intervene methodically and appropriately for proven outcomes.

Novice teachers have little knowledge or confidence in understanding the reading process. They are less aware of state standards in the Reading Panel report than teachers who have been in the field. Most teachers, new and experienced, have no opportunity to practice skills taught through professional development. Training is one thing, application is another.

Summer school is not adequate if a teacher is not taught how to assess or intervene for a child lacking reading skills. Requiring intervention and implementation is not enough if our teachers do not even know the necessary reading skills and stages for specific grades. We have to get to the bottom of this growing literacy gap, or we will not correct it.

Remedy to the downturn. Three initiatives revealed a turn in reading scores and reflected systemic change in teacher training and whole school support. These included 1) Reading First, 2) Haskins Laboratories and 3) ten schools that defied the standard trends in their area and reversed reading score direction. (Senator Williams had requested a study of any schools that had turned the trend around in reading within a demographic cohort. Ten schools were identified).

All three successful cohorts revealed similar whole-school components in reading. They all practiced the majority if not all of the following:

1. Leadership at the top of the school with high expectations of reading, a commitment to on-going teacher training in reading and data-driven decision- making.

2. Use of reading assessments with proven validity and reliability.

3. Early identification and intervention for struggling readers with on-going assessment to determine the next phase of interventions.

4. Literacy or curriculum specialists who provide job-embedded professional development, modeling instructional practices and coaching classroom teachers, and who provide direct instruction to students in small groups (interventions).

5. Regular and frequent monitoring of individual student progress as well as group trends.

6. Professional development based on classroom observations and data.

7. Strong instructional leadership and appropriate instructional materials.

8. Strong emphasis on data and shared accountability.

9. Regular school-based literacy team meetings (administrator, reading specialists, coaches, grade level representatives, and other appropriate personnel).

The group visited all legislation passed on reading by this Committee (see enclosed). Literacy policy has passed that is strong and state of the art. But it has not been adequately implemented. Resulting from this, there was consensus for the need for a renewed focus on accountability and teacher training. Accountability needs to include a full time person in charge of reading at SDE to oversee legislative intent and early reading excellence. There is an unfilled position in SDE to oversee Early Reading Success in CT. Teacher training should include embedded professional development with coaching at the classroom level as well as quality and significantly improved teacher training for teachers in training and current teachers in the classroom.

Those at the *Turning the Trend in Reading Forum* on 1/31/06 agreed that the most important remedy to our reading downturn was job-embedded professional development in reading in the priority schools districts. Connecticut lacks a comprehensive coaching model of job-embedded professional development in reading, which is contributing to the literacy downturn among our students. The Commissioner of Education says, "Teachers must receive job embedded professional development through instructional coaching at the classroom level. More teaching time with the same quality of teaching will not result in increases student performance."

The group agreed that teaching children to read is a complex, multi-faceted process comprised of many core components. In order to ensure that teachers are trained thoroughly and well, teacher-training institutions must do the following:

- Set standards for what teachers need to know and be able to do for successful reading instruction.
- Base instruction on evidence-based research used as the core for developing teacher competencies outlined in the Connecticut Blueprint for Reading Achievement.
- Test what teachers know in each of the components to determine a baseline against which to measure teachers' progress in learning these competencies.
- Build teachers' knowledge and expertise in one area of literacy at a time aiming for mastery rather than exposure, giving them time to practice with their students.
- Define qualifications for reading specialists and provide these highly-trained reading experts to act as mentors and coaches to assist teachers in integrating the core components of reading instruction in their classrooms.
- Deliver professional development to teachers targeted to mastery of these standards that is systematic, explicit, and cumulative – that is, each workshop builds on the one before it – and teachers receive follow-up in their classrooms to support their understanding, solidify their knowledge and ensure that the techniques become standard practice in their classrooms.
- Train teachers to use curriculum-based, progress-monitoring assessments to guide their instruction so that each student's instruction is differentiated and monitored for response to instruction.

Legislative and Budget Action Suggestions:

1. Ensure that the Early Reading Success dollars are spent wisely so that we can continue to do the work of training teachers well. Currently there is no such accountability. Use the reading plan portion of the Early Reading Success budget for teacher training in reading and embedded professional development with coaching in the classroom.

2. Fill the open and unfilled Early Reading Success position immediately at SDE with someone highly skilled in early reading success, assessment and intervention who can oversee the legislative intent of reading laws and ensure the implementation of the Reading Panel Report and its findings in teacher training and practice. This position is unfilled leading to no coordination of reading statewide within the SDE.

3. Create a reading coach model of teacher training in the classroom that prepares all teachers, K-3, in early literacy assessment, intervention and practice so that every child will learn to read on grade level by fourth grade. This model based on proven research in our state and nationally, has led to the greatest number of children moving forward, not entering special education and successfully mastering the art of reading.

4. Increase the Pool of Qualified Reading Specialists: Authorize Haskins Laboratory as an Alternative Route to Certification (ARC) institution to increase the supply of well trained reading specialists utilizing research based practice.

5. Improve Pre-service Teacher-Training by Partnering with the public teaching colleges in CT to ensure substantive courses in the science of teaching reading as recommended by the State Reading Panel Report and codified in statute. Create explicit curricular goals and a comprehensive language arts curriculum for reading

6. Methodically implement all of the recommendations in the Reading Panel report. This report should become the primary tool for teacher training, curriculum development and early reading success in Connecticut. It should alter reading requirements in higher education as teachers prepare for their profession. (Now one cannot get a copy of the report when they call for it).

For the record, I include a summary of all the legislation that this committee has passed on reading. The policies are strong and excellent. They have not been fully implemented and children are declining in reading skills.

HB 5517-Universal Preschool

The facts are uncontested that the underpinnings of a child's ego, self-esteem, and lifelong learning patterns are sewn together before kindergarten. The early years are not simply fit for babysitting. They are in fact where language begins, where the capacity to care for others begins----or does not begin---it is in the under five years that a child develops mental health problems and where the severe behavioral underpinnings can be anchored to implode later.

Unlike the body, which takes 20 years to mature to 95% of its full size, the brain develops to 90% of its capacity in the first five years. At birth, children's brains have almost all the brain cells or neurons, they will every need. However, these neurons are not yet linked into the networks necessary for learning and complex functioning. Between birth and school age a process of "sculpting" occurs: some neural connections are made or reinforced and others die away. Early childhood experiences shape these connections, helping to determine which ones are maintained and which are lost.

We perhaps have created a false divide between what children need in early elementary and what they need when they are young. The young can learn and develop the patterns that can undo the achievement gap in race and poverty. But we need to start young.

A few suggestions.

1. CT school readiness legislation is working. Rather than building other systems that might create fragmentation, align any preschool growth, be it in the suburbs, rural sector or urban sector, to the successful school readiness law that you authored.

2. The outcome data shows children more prepared for school in social, emotional, numeracy, literacy, and small motor skills. The research informs us that one year is not enough. Just doing a preschool program for four year olds will not work. It needs to be for both three and four year olds so that children have two years of preschool access.

3. Those most in need of preschool are still waiting for programs. We have 4000 children without preschool in ERG I alone. Don't allow a universal framework to push those most in need further from the entry line.

Please measure a universal framework against budget possibilities to ensure that those who have the most to learn in school readiness schools are not left out or are only able to be in a 2.5 hour program due to the resource needs of a universal strategy. Low income children need to be in preschool full-day.

4. Last year, many towns lost slots due to a lack of carry-over funds, new rates and the add-on of a priority school. Over 150 slots were lost to towns. Programs had to close. Hartford lost over 100 slots and is still reeling from having turned so many children in need away. I would suggest this needs to be remedied before we expand school readiness further.

We need universal preschool. But with limited dollars, our priority should first go to those most in need. The research tells us that programs will not endure if they are not universal and publicly utilized across region and class. Children learn more when they are in integrated environments.

However, low income children gain the most from quality preschool. The savings to the state and the outcome data inform us that our investment is most returned for low income children who stay on course with such early intervention.

HB 376 An Act Concerning Full-Day Kindergarten

We cannot build a school readiness system and then expect children to go to kindergarten for 2.5 hours. Full day programs that create a learning bridge between preschool and first grade are paramount. For those towns that need full day kindergarten and currently are without, this bill offers the opportunity to begin the necessary programming.

HB 5513 An Act Concerning Parental Involvement

A growing body of research suggests that when parents are involved in their children's learning, the children do better and the educational institutions also improve. Children with parents' involved in their learning reflect better grades, test scores, long-term academic achievement attitudes and behavior than those with uninvolved parents. Federal and State

policy has begun to utilize these findings. Programs throughout the nation are forging new partnerships with providers, parents and the community leaders.

Parents need to know how their children are doing in school to best support learning at home. Concurrently, teachers need to know what parents observe in children at home and in the community to partner in teaching the child.

Parent community involvement is an unfulfilled resource that has the potential to influence the lifelong learning of the child (Anne T. Henderson, 1988).

What We Know About Parent Involvement. Parent involvement with young children has deep and long-term effects on children's learning. Research shows that when parents are involved with learning in positive ways, positive results occur. Child development is enhanced, attendance and achievement improve, and parents and students develop better attitudes toward school. For example:

1. Four decades of research establish a link between parent-child interactions and a young child's reading skills (Milner).

2. When teachers involve parents in home-learning activities with their children, the family benefits. Parents learn how to teach their own children. The children's skills increase and e they are further motivated by their parents' focus on their program (Bloom).

3. Children who have parents' involvement in their learning show better grades, test scores, long-term academic achievement attitudes and behavior than those with uninvolved parents (Anne Henderson, 1988).

4. Professionals in education require training to affect their role in providing and sustaining effective high quality parent involvement.

Title One has recognized the importance of parent involvement in student learning for decades. Title One is the largest federal aid program for elementary, middle and high schools. Title One is based on three values-

1. All students should work toward the same high standards as everyone in the school or district.
2. Local school districts and parents know best what their students need to succeed; and

3. Parents are partners in helping all students achieve.

Including parent engagement in school profiles will facilitate this process. SDE is wishing to come up with the indicators for this so that the work is not burdensome to the school districts and the goal is met. We fully support this direction.

Child Nutrition. Childhood obesity has entered our civic discourse with a bang. We frequently recite the alarming statistics that have entered our vocabulary since the U.S. Surgeon General labeled this condition a public health epidemic.

- Nationally the prevalence of overweight children nearly doubled in the past 20 years and nearly tripled for adolescents.
- Adult obesity in Connecticut has nearly doubled in just over a decade – from 10.9% in 1991 to 18.0% in 2002. Most Connecticut adults (54.8%) are overweight or obese.
- Most obese children grow up to be obese adults and suffer from the conditions associated with obesity, including heart disease, stroke and diabetes.
- Obese children are more likely to smoke, consume alcohol and experiment with drugs as well as have self-esteem and health issues which negatively impact their studies and social life in school.
- Obesity has costly direct and indirect consequences for families, health systems and the government programs that pay for emergency and long-term illness care. Obesity is associated with premature death and disability, increased health care costs and lost productivity.
- In Connecticut, obesity-related health problems for adults cost an estimated $856 million in annual medical expenses.

To see how difficult and long-term this issue will be to solved, take a look at the issue from the perspective of young people themselves.

When it comes to nutrition and exercise, children today have the deck stacked against them. In the old days, many students would walk to school, enjoy a healthy recess and physical education class, play late at the local park, and eat healthy home-cooked meals with vegetables from the garden behind their home. Our generation spent many hours getting fresh air and moving around outside, and we digested lots of real food. No wonder so few children and teens were overweight.

Today, children have little chance of walking to school. They are more likely to live several miles from school and to have to get a ride there and everywhere. For those who do live within walking distance from school, there is a pretty good chance that the walk is too dangerous – due to fast-moving traffic, a lack of sidewalks or the risk of crime. Although we know from research how important regular exercise is to education, busy school days often leave only a few minutes for outside play. And students too often eat unhealthy food, both at school and in restaurant or take-out food when busy parents don't have time to cook. In fact, healthy foods such as raw fruits and vegetables, or even prepared foods with low fat content are more expensive and more difficult to locate. After school each day, television, computer and video games compete for attention, overshadowing more active options like hopscotch and soccer.

It is really no surprise then that thousands of Connecticut children are overweight or at risk of becoming overweight, and that an increasing number are at risk for Type 2 diabetes. We used to call this adult-onset diabetes, but the disease has become so common among young people that you don't often hear it called that anymore.

With the help of this Committee's leaders and others, over the past year Connecticut has begun to take the obesity issue very seriously. I am pleased to report several positive developments. The Connecticut Department of Public Health (DPH) and the Department of Education (SDE) have both published important state plans for healthy living and eating. DPH has added obesity staff. The Commission on Children (COC) and DPH has jointly announced plans for a state advisory council to focus on childhood obesity prevention. School districts across the state are developing wellness policies to be in place by this fall. COC and the Connecticut Conference of Municipalities are working with mayors who want to take the lead in strengthening the health of their community's children. Yale University has opened the Rudd Center, an obesity resource center. All around the state, innovative solutions to this problem are emerging – from family walking programs in Norwalk, pedestrian trails in Mansfield, and a school food pilot program in New Haven to farmer's markets in East Hartford and Stratford.

Energy is building around media health promotion, school-based nutrition, education and physical activity programs, programs for parents and caregivers, neighborhood and community planning and training for medical professionals.

While we celebrate the progress being made, this is a long-term issue that took decades to emerge and that will take dedicated attention for years to solve. We need to take action this year, and the next, and the year after. Recall the long-term campaigns on tobacco prevention or child safety seats. It will take a long time to restore health to our state's children.

The nutrition legislation before you is an excellent next step.

Raised Bill 381, *An Act Concerning Healthy Food and Beverages in Schools*, would limit beverages sold in schools to milk, fruit and vegetable juice, and water. The bill would help school districts provide healthy foods by increasing the school lunch reimbursement (a $0.10 increase per meal for those schools whose non-federal meal program foods meet SDE nutrition standards).

Raised Bill 375, *An Act Concerning Connecticut-Grown Food in Schools*, would establish state farm-to-school programs to promote the purchase of Connecticut-grown farm products by schools through school meals and classroom programs, and at farms and farmers' markets.

The Commission on Children strongly supports these bills. Providing nutritious foods to students has a beneficial impact on students' academic performance, attendance and health. It makes little sense for schools to sell unhealthy food that harms children, interferes with their learning, and worsens the obesity epidemic.

School is where children learn productive study and work habits that help prepare them for the workforce. It is also where they learn healthy habits through health and immunization programs, health curricula, interactions with school nurses and other health-related experiences. School should reinforce healthy habits, not contradict them. This legislation would improve the foods served in schools and reward schools that value healthy eating, while not interfering with the right of a parent to pack what they see fit for their child to drink or eat at school.

We have two suggestions to amend Raised Bills 381 and 375.

Recommendation #1: Statewide Obesity Trend Data

We strongly recommend that language be added to the legislation before you to measure statewide and local progress toward reducing the incidence of childhood obesity. You will notice that this testimony began with statistics, but there were no Connecticut youth obesity statistics. That is because no such official statistics exist. The state has only limited unofficial statistics from individual communities and broad statewide estimates based on national data.

We should chart our state's progress in preventing obesity by providing for statewide Body Mass Index (BMI) data collection and analysis. According to the Centers for Disease Control and Prevention, BMI-for-age is the best way to measure student progress. In Connecticut, SDE already asks pediatricians to fill in each student's BMI on the school health assessment form.

The attached language ("Recommended childhood obesity legislative language on statewide Body Mass Index (BMI) data collection") would create a partnership between the schools, SDE and DPH to use the school health assessment form data to chart annual BMI trends for students. This would be aggregate data – completely confidential and without any health "report card" – as the state already does for asthma and immunization. We strongly encourage the Committee to add this language to the legislation.

Recommendation #2: State Childhood Obesity Council

We also recommend that the Committee add language from a 2005 bill that would create a statutory state childhood obesity council (Substitute H.B. 6631, File Version 203). This legislation would support the emerging DPH-COC partnership by drawing government and non-government leaders together to help implement a common strategy to prevent childhood obesity. Other states have taken a similarly comprehensive approach to coordination on this issue.

Anti-Bullying Legislation. The students and parents of Connecticut want safe, caring communities and schools. Learning without fear should be a right of every student in Connecticut. All school activity should be carried out with the fundamental values of respect, tolerance and safety.

Bullying is an all-too-common and harmful form of violence among children that threatens that safe learning environment. Bullying among primary school children has been identified as one precursor to more aggressive and sometimes violent behavior in later grades.

In Connecticut and throughout the United States, bullying is a very serious issue:

- Fourteen percent of U.S. schoolchildren reported being the victims of bullying within the last six months. Of those students who reported lower grades, victims of bullying were more likely to report receiving D's and F's than their no bullied counterparts (U.S. Department of Education, 2005)

- In Connecticut, bullying has increasingly been linked to youth suicides, according to the Child Advocate.

- A 2002 U.S. Secret Service report that found that bullying had played a major role in several school shootings.

- More Connecticut parents are turning to courts to sue schools when bullying issues are not resolved.

- Bullying that occurred on a Stonington school class trip to Washington, DC resulted in the town's insurer seeking to have parents of the bullies pay some or all of damages if the school was found liable.

Raised Bill 5548, *An Act Concerning School Reporting of Bullying Incidents,* follows up on the 2002 anti-bullying law (CGS § 10-222d) that required schools to enable reporting of bullying acts, to maintain a list of the number of verified acts of bullying and make the list available for public inspection, to institute bullying policies and an intervention strategy, and to take other steps to address bullying.

R.B. 5548 would require school principals to report verified acts of bullying to the local board of education. It would require each board to report the number of such acts in each school to SDE.

Under current law, schools keep data on the number of incidents. This tells us almost nothing about the content or effectiveness of the school's bullying policies and practices.

Our concern with R.B. 5548 is that, taken alone, the bill focuses attention on the number of acts of bullying and fails to strengthen the implementation and analysis of effective anti-bullying policies.

To that end, we would urge the Committee to support Raised Bill 5504, *An Act Concerning A Safe Learning Environment For Children And Youth*, which calls on SDE to conduct regular analysis of the effectiveness of bullying policies, distribute information about best practices in addressing bullying, and document what technical assistance and training are needed by school districts in order to achieve a safe learning environment. R.B. 5504 would also establish an SDE Ombudsperson to help resolve parent complaints about bullying and would help schools implement best practices through the state's Safe Learning Grant Program.

Without a state-level review and analysis of the school policies on bullying instituted over the past four years, we lack data on what research-based models have been used by schools and on how their policies and practices have impacted the school environment. An Ombudsperson would provide parents of children affected by bullying with assistance to help address problems by working with schools. This assistance could in fact reduce the incidence of lawsuits. Re-funding the Safe Learning Grant Program would provide competitive grants to assist school districts in developing a school environment where children learn in safety without fear of physical or verbal harm or intimidation.

Raised Bill 5563, *An Act Concerning Bullying Policies in Schools and Notices Sent to Parents or Legal Guardians*, would require students to be notified annually of the process by which they may make anonymous reports of bullying, include school buses as a possible place in the definition of bullying, and apply school bullying policies to bullying outside of the school setting if it has a negative impact on a student's academic performance or safety in school. The bill would direct school boards to develop case-by-case interventions for addressing repeated incidents of bullying by or against a particular individual. It would require that a parent with whom a student does not reside shall receive all school notices sent to the other parent.

The Commission on Children strongly supports R.B. 5563, especially if it is passed in conjunction with R.B. 5504. R.B. 5563 would improve the school's internal response to bullying. R.B. 5504 would improve the state's response and the level of assistance available to schools on this issue.

Conclusion

Thank you for this opportunity to present the views of the Commission on Children on these important bills. We look forward to working with the Committee to ensure that every child has a healthy and safe start in life.

Recommended childhood obesity legislative language on statewide Body Mass Index (BMI) data collection

Section 1. Section 10-206 is repealed and the following is substituted:

(a) Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments pursuant to the provisions of this section. Such assessments shall be conducted by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, or by the school medical advisor to ascertain whether such pupil is suffering from any physical disability tending to prevent such pupil from receiving the full benefit of school work and to ascertain whether such school work should be modified in order to prevent injury to the pupil or to secure for the pupil a suitable program of education. No health assessment shall be made of any child enrolled in the public schools unless such examination is made in the presence of the parent or guardian or in the presence of another school employee. The parent or guardian of such child shall receive prior written notice and shall have a reasonable opportunity to be present at such assessment or to provide for such assessment himself or herself. A local or regional board of education may deny continued attendance in public school to any child who fails to obtain the health assessments required under this section.

(b) Each local or regional board of education shall require each child to have a health assessment prior to public school enrollment. The assessment shall include: (1) A physical examination which shall include hematocrit or hemoglobin tests, height, weight, blood pressure, and, beginning with the 2003-2004 school year, a chronic disease assessment which shall include, but not be limited to, asthma as defined by the Commissioner of Public Health pursuant to subsection (c) of section 19a-62a and, beginning with the 2006-2007 school year, body mass index-for-age as defined by the Commissioner of Public Health pursuant to section 2 of this bill. The assessment form shall include (A) **[**a**]** check boxes for the provider conducting the assessment, as provided in subsection (a) of this section, to indicate an asthma diagnosis and body mass index-for-age, (B) screening questions relating to appropriate public health concerns to be answered by the parent or guardian, and (C) screening questions to be answered by such provider; (2) an updating of immunizations as required under section 10-204a, provided a registered nurse may only update said immunizations pursuant to a written order by a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378; (3) vision, hearing, speech and gross dental screenings; and (4) such other information, including health and developmental history, as the physician feels is necessary and appropriate. The assessment shall also include tests for tuberculosis, sickle cell anemia or Cooley's anemia and tests for lead levels in the blood where the local or regional board of education determines after consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, that such tests are necessary, provided a registered nurse may only perform said tests pursuant to the written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378.

(c) Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments in either grade six or grade seven and in either grade ten or grade eleven. The assessment shall include: (1) A physical examination which

shall include hematocrit or hemoglobin tests, height, weight, blood pressure, and, beginning with the 2003-2004 school year, a chronic disease assessment which shall include, but not be limited to, asthma as defined by the Commissioner of Public Health pursuant to subsection (c) of section 19a-62a and, beginning with the 2006-2007 school year, body mass index-for-age as defined by the Commissioner of Public Health pursuant to section 2 of this bill. The assessment form shall include (A) **[**a**]** check boxes for the provider conducting the assessment, as provided in subsection (a) of this section, to indicate an asthma diagnosis and body mass index-for-age, (B) screening questions relating to appropriate public health concerns to be answered by the parent or guardian, and (C) screening questions to be answered by such provider; (2) an updating of immunizations as required under section 10-204a, provided a registered nurse may only update said immunizations pursuant to a written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378; (3) vision, hearing, postural and gross dental screenings; and (4) such other information including a health history as the physician feels is necessary and appropriate. The assessment shall also include tests for tuberculosis and sickle cell anemia or Cooley's anemia where the local or regional board of education, in consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, determines that said screening or test is necessary, provided a registered nurse may only perform said tests pursuant to the written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378.

(d) The results of each assessment done pursuant to this section and the results of screenings done pursuant to section 10-214 shall be recorded on forms supplied by the State Board of Education. Such information shall be included in the cumulative health record of each pupil and shall be kept on file in the school such pupil attends. If a pupil permanently leaves the jurisdiction of the board of education, the pupil's original cumulative health record shall be sent to the chief administrative officer of the school district to which such student moves. The board of education transmitting such health record shall retain a true copy. Each physician, advanced practice registered nurse, registered nurse, or physician assistant performing health assessments and screenings pursuant to this section and section 10-214 shall completely fill out and sign each form and any recommendations concerning the pupil shall be in writing.

(e) Appropriate school health personnel shall review the results of each assessment and screening as recorded pursuant to subsection (d) of this section. When, in the judgment of such health personnel, a pupil, as defined in section 10-206a, is in need of further testing or treatment, the superintendent of schools shall give written notice to the parent or guardian of such pupil and shall make reasonable efforts to assure that such further testing or treatment is provided. Such reasonable efforts shall include a determination of whether or not the parent or guardian has obtained the necessary testing or treatment for the pupil, and, if not, advising the parent or guardian on how such testing or treatment may be obtained. The results of such further testing or treatment shall be recorded pursuant to subsection (d) of this section, and shall be reviewed by school health personnel pursuant to this subsection.

(f) On and after February 1, 2004, each local or regional board of education shall report to the local health department and the Department of Public Health, on an annual basis, the total number of pupils per school and per school district having a diagnosis of asthma, and, on and after February 1, 2008, the total number of pupils per school and per school district who

are underweight, at risk for overweight, or overweight based on body mass index-for-age (1) at the time of public school enrollment, (2) in grade six or seven, and (3) in grade ten or eleven. The report shall contain the asthma and body mass index-for-age information collected as required under subsections (b) and (c) of this section and shall include pupil age, gender, race, ethnicity and school. On and after February 1, 2008, each local or regional board of education shall report to the local health department and the Department of Public Health, on an annual basis, (1) the number of students receiving a pediculosis, nutrition, mental health or dental screening, or any other screening as determined by the Department of Education, (2) the number of such students referred to an outside provider as a result of the screening, and (3) such other health services program information as determined by the Department of Education, in consultation with the Department of Public Health.

(g) Beginning on October 1, 2004, and every three years thereafter, the Department of Public Health shall review the asthma screening information reported pursuant to this section and shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education concerning asthma trends and distributions among pupils enrolled in the public schools. Beginning on October 1, 2008, and annually thereafter, the Department of Public Health shall review the body mass index-for-age information reported pursuant to this section and shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education concerning overweight and obesity trends and distributions among pupils enrolled in the public schools, and making recommendations to address health concerns identified in the report. Each **[**The**]** report required pursuant to this subsection shall be submitted in accordance with the provisions of section 11-4a and shall include, but not be limited to, trends and findings based on pupil age, gender, race, ethnicity, school and the education reference group, as determined by the Department of Education for the town or regional school district in which such school is located.

Sec. 2. (NEW) (a) Not later than January 1, 2008, the Commissioner of Public Health shall establish and maintain a system of monitoring physical development and growth of Connecticut students. Such system shall include, but not be limited to, annual collection of student age and gender, height and weight, and body mass index-for-age. The monitoring system may include reports of the number of students overweight, at risk for overweight, or underweight in the state. Such system shall be used by the Commissioner in estimating annual incidence and distribution of overweight or at risk of overweight students in the state, including, but not limited to, such incidence and distribution based on age, gender, grade, school enrollment and the education reference group, as determined by the Department of Education, of the town or regional school district.

(b) Not later than October 1, 2006, the Commissioner of Public Health shall develop model case definitions of body mass index and body mass index-for-age for purposes of this section and section 10-206.